



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: GIAVCAP

| | | | | |
|---|---------------------|--------------------|-------------------|--------------------------|
| DOCTOR'S ORDERS | | Ht _____ cm | Wt _____ kg | BSA _____ m ² |
| REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form | | | | |
| DATE: | To be given: | Cycle(s) #: | | |
| Date of Previous Cycle: | | | | |
| <input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & diff, platelets day of treatment | | | | |
| May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute | | | | |
| Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Age/ECOG <input type="checkbox"/> Other Toxicity _____ | | | | |
| Proceed with treatment based on blood work from _____ | | | | |
| CHEMOTHERAPY: <input type="checkbox"/> Repeat in three weeks | | | | |
| capecitabine <input type="checkbox"/> 1000 or <input type="checkbox"/> 1250 mg/m ² (select one) x BSA x (_____ %) = _____ mg PO BID x 14 days (refer to Capecitabine Suggested Tablet Combination Table for dose rounding) | | | | |
| RETURN APPOINTMENT ORDERS | | | | |
| <input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in six weeks for Doctor and Cycle _____ & _____. <input type="checkbox"/> Last Cycle. Return in _____ week(s) | | | | |
| CBC & diff, platelets, creatinine prior to each cycle If clinically indicated: <input type="checkbox"/> BUN <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Weekly Nursing Assessment <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests. | | | | |
| DOCTOR'S SIGNATURE: | | | SIGNATURE: | |
| | | | UC: | |